STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00107724. Complaint IN00107724-Substantiated Federal/state deficiencies related to the allegations are cited at F282 and F514. Survey dates: 5/22-23/2012 Facility number: 000215 Provider number: 155322 AIM number: 100267600 Survey team: Ellen Ruppel, RN Census bed type: SNF/NF: 25 NF: 57 Total: 82 Census payor type: Medicare: 2 Medicaid: 64 Other: 16 Total: 82	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 25, 2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interviews, the facility failed to follow physician's orders related to the administration of medications for 1 of 3 residents in a sample of 3 whose records were reviewed. Resident B Findings include: The clinical record of Resident B was reviewed on 5/22/12 at 10:20 a.m., and indicated the resident's diagnoses included, but were not limited to: traumatic brain injury, seizures, hypertension and narcolepsy. The resident was a hospice patient with comfort measures only. Physician's orders, dated 5/10/12, indicated Roxanol 10 mg to control pain was to be given routinely every six hours, to start on 5/12/12.	F0282	1. CORRECTIVE ACTION FOR AFFECTED RESIDENTS: * Medication Treatment Error Report completed; nurse counseled. 2. IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS: * Review checking physician's orders policy with all nursing staff; * Review General Guidelines for Medication Administration including; * Checking the Medication Administration (MAR) for medication & dosing schedule. * Medication administration in accordance with attending physician written orders * Observing medication pass of all nurses by June 22, 2012 3. MEASURES FOR PREVENTION: * Monthly monitor nurses med pass for at least 3 months. * Continue medication pass observation at least annually. * Perform root cause analysis for each medication error. * Provide individual counseling based on Medication Pass Observation, Monthly Med Pass QI and Medication Errors reported. 4. QA FOR PREVENTION: * DON or designee to monthly review medication errors-root cause	06/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The first dose was scheduled for 2:00 a.m., on 5/12/12. Review of the Medication Administration Record (MAR) for May 2012 indicated the first dose was circled as not given. During an interview with RN #2 on 5/22/12 at 2:30 p.m., she indicated the night nurse on 5/12/12 had "missed" the order and had not given the medication as ordered. This federal tag relates to Complaint IN00107724 3.1-35(g)(2)		analysis findings and discuss at monthly QA meeting. * DON or designee to report monthly medication error and follow-up counseling trends at monthly QA meetings. 5. EFFECTIVE DATE: June 22,2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review, the facility failed to maintain complete and accurate records for 2 of 3 residents whose records were reviewed in the sample of 3. Residents B and C Findings include: 1. The clinical record of Resident B was reviewed on 5/22/12 at 10:20 a.m., and indicated the resident was on hospice care and receiving comfort care. Review of the Medication Administration Record (MAR) for the month of April 2012 indicated	F0514	1. CORRECTIVE ACTION FOR AFFECTED RESIDENTS: * In-service all nursing staff regarding Use of the PRN Record, Medication Refusal, and General Documentation Guidelines policies. 2. IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS: * In-service all nursing staff regarding Use of the PRN Record, Medication Refusal, and General Documentation Guidelines policies. 3. MEASURES FOR PREVENTION: * Weekly QI monitoring will be completed on five (5) records per hall; * The Medication Administration Record, PRN list, Treatment Record, and nurses notes will be monitored for accuracy and completeness. 4. QA FOR PREVENTION: * DON or designee will present QI monitoring results at monthly QA	06/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident's dosages of levothyroxin (for thyroid disorder), and Cytomel (for thyroid disorder) were circled as not given on 4/17, 4/18, 4/23 and 4/27/12 at 5:00 a.m. No explanation for why the medications were not given was recorded on the MAR or in the nurses notes. The resident's Dilantin (for seizures) was also circled on 4/27/12, with no indication why it was not given. Review of May 2012 MAR for Resident B indicated Senokot (stool softener) was circled on 5/11/12 at 8:00 a.m., Provigil at 8:00 a.m., (to increase mental alertness) Dilantin at 4:00 p.m., (for seizures) Lasix (diuretic) was circled on 5/2/12 at 8:00 a.m., as not given. There was no explanation in the nurses notes or on the MAR to indicate why the medications were circled. Review of the facility's undated policy related to medication refusals, provided by the Assistant Director of Nursing (ADON) on		meetings. 5. EFFECTIVE DATE: June 22, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/22/12 at 2:45 p.m., indicated, in part, "D. Document by initialing medication in MAR and circling initials. E. Make note on PRN (as needed) sheet that medication was refused. F. Document refusal in nurses notes." No documentation could be found on 5/22/12 at 3:00 p.m., on the PRN sheets or in the nurses notes regarding the circled medications. During an interview with LPN #4 on 5/22/12 at 10:00 a.m., she indicated the facility did not require documentation of circled medications on the MAR, but did have nurses record them on the daily PRN (as needed) record and in the nurses notes. Review of the PRN sheets for the month of May 2012, on 5/22/12 at 10:10 a.m., indicated the circled medications for Resident B were not recorded. During an interview with the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Assistant Director of Nursing (ADON), on 5/23/12 at 9:00 a.m., she indicated she was unsure why the nurses were not documenting the reasons for the circled medications. 2. Resident C was observed on 5/22/12 in bed during the orientation tour at 8:35 a.m. RN #8 indicated the resident was on bedrest due to wounds. She was observed on a low loss air mattress and family members were present. RN #8 indicated Resident C was on hospice care due to her declining condition. During an interview with the family member of Resident C, on 5/22/12 at 2:00 p.m., the family member indicated the resident had been on bedrest since 5/18/12. Review of the Treatment Administration Record (TAR) for May 2012 indicated staff members were indicating Resident C was being gotten up three times a day			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for 1 and 1/2 hours for meals. The record indicated she had been up in a chair on 5/19, 5/20, 5/21 and 5/22/12. During an interview with the ADON, on 5/23/12 at 9:00 a.m., she indicated the resident had not been up in the past four days. This Federal tag relates to Complaint IN00107724. 3.1-50(a)(1) 3.1-50(a)(2)			